Your Anthem Benefits

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STATE OF INDIANA
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2003

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Deductible (Single/Family) *(Applies only to percent (%) copayments)* *Deductibles are commingled Network and Non-network*	For Employees whose annual salary is less than $25,000.00: $0 deductible per Enrollee; $0 per Family For Employees whose annual salary is $25,000.00 to $35,000: $125 deductible per Enrollee; $400 per Family For Employees whose annual salary is more than $35,000.00 $500 deductible per Enrollee; $1,000 per Family
Out-of-Pocket Maximum (Single/Family) *Out-of-Pockets are commingled Network and Non-network*	$1,000 per Enrollee in addition to the yearly deductible. $2,400 per Family in addition to the yearly deductible The out-of-pocket maximum limit accrues on a calendar year basis. After the out-of-pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.
Office Visit	20% Network/40% Non-Network Per Visit
Routine Care	20% Network/40% Non-network: Services include: Well Baby immunizations for eligible dependents under age 2, annual physicals for employees and their eligible covered dependents, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.
Maternity Services	20% Network/40% Non-network
Newborn Initial and Subsequent Care	20% Network/40% Non-network
Inpatient Services	20% Network/40% Non-network
Outpatient Facility Services	20% Network/40% Non-network
Professional/Ancillary/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network
Emergency Illness/Emergency Accident	20% Network/40% Non-network
Ambulance	20%
Radiation/Inhalation Therapy, Speech and Occupational Therapy	20% Network/40% Non-network
Medical Supplies, Equipment and Appliances	20% Network/20% Non-network
Outpatient Therapy Visit Limits	
Physical/Occupational	20% Network/40% Non-network
Speech	20% Network/40% Non-network
Mammogram	20% Network/40% Non-network: Includes 1 per person. per calendar year. Additional mammography services and ultrasounds are covered as determined Medically Necessary by your Physician.
Routine Prostate Antigen Tests (PSA)	20% Network/40% Non-network: Includes 1 per person, per calendar year
Colorectal Cancer Exam/Laboratory Testing:	20% Network/40% Non-network

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY
Diabetes Self Management Training	20% Network/40% Non-network
Diagnostic Services In an office or laboratory	Covered in Full
Diagnostic Services: In a setting other than office or laboratory	20%/Network/40% Non-network
Temporomandibular Joint (TMJ) Services	Outpatient Facility/Provider Individual: 20% Network/40% Non-network TMJ Surgery: 20% Network/40% Non-network TMJ Other Services: $2,500 lifetime maximum for all services (network/non-network)
Private Duty Nursing: Only covered under Home Health Care benefit.	20% Network/40% Non-network: $5,000 plan maximum, per enrollee
Home Health Care: No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network Private Duty Nursing limited to $5,000.00 Plan Maximum per Enrollee
Dental Care	20% Network/40% Non-network
Accidental Dental Care Caused by an accidental injury after the employee's effective date of coverage	20% Network/20% Non-network
Home IV Therapy	20% Network/40% Non-network
Employee Assistance Program	Provides consultation and referral services for human concerns for employees and their household members.
Managed Mental Health including Substance Abuse	Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed. The deductible does not apply to Managed Mental Health Care Benefits IN-NETWORK BENEFITS: *Inpatient and Outpatient Services-paid 100% of the negotiated diem rate, 365 days per confinement, 90-day renewal period. *Intensive outpatient (IOP)-100% of negotiated rate Substance abuse benefits-100% of the negotiated rate Limits: 35 visits per calendar year No visit limitation for mental illness OUT-OF NETWORK BENEFITS: *Inpatient and Outpatient Services-Day limit per enrollee are 365 days per confinement, 90 day renewal period 35 days per confinement for substance abuse Benefits paid: 60% *Intensive outpatient (IOP) Benefits paid: 60% of what would have been paid if treatment were in the network Limits: 35 visits per calendar year for substance abuse No visit limitation for mental illness *THESE SERVICES MUST BE CERTIFIED BY CONTRACTOR TO RECEIVE BENEFITS
Lifetime Maximum	$1 million Network and Non-network combined (Excluding human organ and tissue transplants)
Human Organ and Tissue Transplants[3]	20% Network/40% Non-network Separate 1 million contract maximum See contract for other maximums and exclusions.

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: 100% of allowable cost after copayment up to a 34-days of medication or 100 units	Combined $25 deductible for retail and mail order per person per calendar year. 10% generic 20% brand	 30% 40%
Anthem Rx Direct Mail Service: 100% of allowable cost after copayment up to a 90-day supply	Combined $25 deductible for retail and mail order per person per calendar year. 10% generic 20% brand The network penalty will be waived if there is no network pharmacy within 12 miles of the participants home. **The prescription drug copays applies to the medical out-of-pocket.**	 30% 40%
Utilization Management	50% penalty for non compliance	

See Benefit Booklet for Exclusions

Note:

- *Dependent age: to the end of the calendar year of age 19; age 23.*

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.